STATE OF MICHIGAN

DEPARTMENT OF LICENSING & REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121723-001**

United Healthcare Insurance Company
Respondent

Issued and entered
this 15th day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. BACKGROUND

On June 3, 2011, XXXXX (Petitioner) filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified United Healthcare Insurance Company (UHC) of the external review request and asked for the information it used to make its final adverse determination. On June 7, 2011, UHC furnished the information. After a preliminary review of the material submitted, the Commissioner accepted the request on June 14, 2011.

The issue here can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

From March 8 to September 7, 2010, the Petitioner was covered under a short-term student medical insurance policy (the policy) underwritten by UHC. The master policy was issued to the XXXXX in XXXXX.

On April 30, May 10, and May 13, 2010, the Petitioner had laboratory tests performed by XXXXX. UHC initially denied coverage for the April 30 and May 10 tests ruling they were

related to a pre-existing condition and were therefore excluded under policy. However, during the internal grievance process and the pendency of this external review, UHC reviewed the claims and reprocessed all of them according to the terms of the policy except for the two tests performed on April 30.

UHC maintained its denial of coverage for CPT codes 80061 (lipid panel) and 83721 (low-density lipoprotein cholesterol test) as treatment of the pre-existing condition of hypertension. The Petitioner appealed the denial through UHC's internal grievance process. UHC upheld its original determination and issued its final adverse determination letter dated April 1, 2011, which advised the Petitioner of her right to an external review by the Commissioner.

III. ISSUE

Did UHC correctly deny coverage for the Petitioner's April 30, 2010 laboratory tests?

IV. ANALYSIS

Petitioner's Argument

In her request for external review, the Petitioner wrote:

> My claims were denied due to a pre-existing condition. However, on those dates I was not being seen for any condition, I was being seen for an annual checkup. These services are for the lab work done for my annual checkup. But United Healthcare has denied them all. I was not being seen for any pre-existing condition.
>
> While I was there the doctor refilled all of my medications. This was a part of my checkup. But I did not go to the doctor for any condition. It was just a checkup.

The charge for CPT code 80061 was $36.00; the charge for CPT code 83721 was $28.00. The Petitioner believes the tests were not for treatment of a pre-existing condition and UHC should cover them.

Respondent's Argument

In its April 1, 2011 final adverse determination UHC stated:

> Under the Mandated benefits for the State of Michigan, a Pre-existing Condition is defined as: "…a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months immediately prior to

> the Insured's Effective Date under the policy." The effective date of the policy is March 8, 2010.
>
> Under Exclusions and Limitations of the policy, it states: "No benefits will be paid for: a) loss or expense caused by or resulting from; or b) treatment, services or supplies for, at, or related to: Pre-existing Conditions, except for individuals who have been continuously insured under the American Bar Association Law Student Division…student insurance policy for at least 12 consecutive months; The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy."
>
> The medical records…have been reviewed by an Independent Medical Reviewer. The reviewing physician is board certified in Internal Medicine.
>
> The Independent Medical Reviewer has determined that the condition of Unspecified Essential Hypertension, ICD diagnosis code 401.9, for the services performed on April 30, 2010 is a Pre-existing Condition, due to the fact that you were taking the prescribed medication Lopressor within six months immediately prior to your effective date. The April 30, 2010 expenses were denied correctly in accordance with the terms, provisions and exclusions of the policy and no benefits are due.

In a June 7, 2011, letter in response to the external review, UHC further explained:

> In reviewing the claims for the services on 04/30/10 and 05/10/10 it is noted that on these claims only two charges reflected that the services were performed for the diagnosis of 401.9 – Unspecified Essential Hypertension. These were for the charge of $36 for Current Procedural Technology code (CPT) 80061 – Lipid Panel and the charge of $28 for CPT – 83721 Lipoprotein Dir. The remainder of the charges reflected that the diagnosis was for 78079 – Other Malaise and Fatigue.
>
> Thus, upon completion of the medical review all charges were to be reconsidered in accordance with the policy provisions with the exception of the two that were for the diagnosis of Unspecified Essential Hypertension. However, the claims inadvertently did not get routed to the correct area for re-adjudication.
>
> * * *
>
> Please note, these claims do reflect that these services were rendered for the treatment of a diagnosis and not for an annual/routine exam. . . .

Commissioner's Review

The Petitioner's insurance policy excludes coverage for treatment of pre-existing conditions. In the "Exclusions and Limitations" section of the policy it states:

> No benefits will be paid for: a) loss or expense caused by or resulting from; or b) treatment, services or supplies for, at, or related to:
>
> * * *
>
> 22. Pre-existing Conditions, except for individuals who have been continuously insured under the American Bar Association Law Student Division student insurance policy for at least 12 consecutive months; The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy . . .

"Pre-existing condition" is defined in the policy:

> **Pre-Existing Condition** means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 12 months immediately prior to the Insured's Effective Date under this policy.

However, this definition differs from the one found in Section 3406f(1)(c) of the Michigan Insurance Code, MCL 500.3406f(1)(c):

> (1) An insurer may exclude or limit coverage for a condition as follows:
>
> * * *
>
> (c) For an individual covered under a group policy or certificate covering more than 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the policy or certificate.

In its final adverse determination, UHC acknowledged that Michigan's pre-existing condition limitation applied to the Petitioner. Thus, the "look back" period for determining a pre-existing condition is only six months in the Petitioner's case. Thus, she must have had a condition "for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months" before her effective date of coverage, i.e., between September 8, 2009, and March 8, 2010.

The Commissioner agrees with UHC that the Petitioner had been diagnosed with hypertension on September 2, 2009, and was prescribed Lopressor. That date, however, is prior to the six-month look back period. It is not enough under Section 3406f(1)(c) for a condition to simply "exist" during the look back period. It must also be shown that "medical advice,

diagnosis, care, or treatment was recommended or received" for the condition, and the record here does not establish that.

The Commissioner concludes and finds that UHC failed to show that the Petitioner had a pre-existing condition when she sought treatment after her coverage with UHC was effective.

V. ORDER

The Commissioner reverses United Healthcare Insurance Company's final adverse determination of April 1, 2011. UHC shall cover the disputed laboratory tests of April 30, 2010 (CPT codes 80061 and 83721), subject to the terms and conditions of the policy, within 60 days of the date of this Order and shall, within seven (7) days of providing coverage, furnish the Commissioner with proof it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner